

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019544
STATE FILE NUMBER

Registrar No. 5033

Registration District No. _____ Primary Registration District No. _____

FILED JUN 4 1959

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips | | d. STREET ADDRESS (If outside, give location) 2809 Dayton | |
| Length of stay in 1b _____ | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Helan Jennette Rainey | | | 4. DATE OF DEATH Month Day Year May 21 1959 |
| 5. SEX female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 19 Aug. 56 |
| 9. AGE (In years last birthday) 2 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) St. Louis Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME Ben Perry | 13b. MOTHER'S MAIDEN NAME Ruth Rainey | 14. NAME OF HUSBAND OR WIFE xxx | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) xx | 16. SOCIAL SECURITY NO. xx | 17. INFORMANT Ruth Rainey 2809 Dayton Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningococcic Meningitis | | | INTERVAL BETWEEN ONSET AND DEATH _____ |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | 057.0 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. _____ | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ in on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Paul J. Simon (Deputy Registrar) | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 5/28/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 26 May 1959 | 23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Mo. |
| 24. FUNERAL DIRECTOR Reliable Funeral Sys. 1389 N. Union | ADDRESS | 25. DATE RECD. BY LOCAL REG. MAY 25 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Health, Welfare, Public Service

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John K. Cunningham*

Licensed Embalmer No. *4476*

P. O. Address *9405 mar*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.